Supreme Court, U.S.
FILED
031507 APR 26 2004
OFFICE OF THE CLERK

No. Record No. 03-1698

IN THE SUPREME COURT OF THE UNITED STATES

LEON HARRELL,

Petitioner,

v.

C NA INSURANCE COMPANIES, CONTINENTAL CAUSALTY COMPANY, QUORUM HEALTH GROUP, INC. AND QHG OF SOUTH CAROLINA, INC. d/b/a CAROLNIA'S HOSPITAL SYSTEM GROUP LONG TERM DISABILITY PLAN

Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

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QUESTIONS PRESENTED

1. **Where an original decision to deny benefits is an abuse of discretion, as a matter of law, should a plan administrator's upholding of the unjustified decision be considered an abuse of discretion as well?**

2. **Should a discovery request by a plan participant's attorney considered a written request for plan documents, for the purposes of 29 U.S.C. (s) 1132 (c)?**

3. **Under an evaluation of whether to award attorney's fees, should a Plaintiff be considered to have succeeded on the merits if the Court has imposed liability and awarded damages on one of the Plaintiff's causes of action?**

4. **Is the issue of whether discovery requests can trigger liability under 29 U.S.C. (s)1132(c) for a plan administrator which fails to produce a plan document with in 30 days of the request, a novel issue of law, which could be important to future Parties?**

TABLE OF CONTENTS

QUESTIONS PRESENTED i

TABLE OF AUTHORITIES v

OPINIONS BELOW 1

JURISDICTION 1

CONSTITUTINOAL PROVISIONS AT ISSUE 1

STATUTORY PROVISIONS AT ISSUE . . . 1

STATEMENT OF THE CASE 2

REASONS FOR GRANTING THE WRIT OF CERTIORARI 4

I. The Court should have considered the evidence in the record which shows that Pam Ward and the Appeals Board were employees of CNA Insurance Companies, creating a conflict of interest. 5

II. The evidence upon which the Appeal Board relied in deciding that there was no objective medical evidence submitted concerning Harrell's

disabled status does not meet the "substantial evidence" standard set forth in Ellis v. Metropolitan Life Ins. Co., 126 F.3d 228, 232 (4th Cir. 1997). 8

III. The Appeals Board's refusal to recognize Dr. Booth's report concerning a medical examination of Harrell on May 21, 1998 as "objective Medical evidence" upon which it could make a determination of disability renders other language in the plan meaningless. 8

IV. Plaintiff requests reconsideration of the Court's findings and decision concerning an award under 29 U.S.C. (s) 1132 (c). 14

A. Discovery requests should be considered a "written request under 29 U.S.C. (s) 1132 (c)." 15

B. Delay in judicial proceedings without legal justification is recognized as prejudicial under the Federal Rules of Civil Procedure. 16

C. Refusal to produce the Plan during discovery is proof of bad faith. 18

D. A showing of prejudice is not a requirement for the imposition of sanctions under Sedlack. 18

E. That Harrell could have obtained the plan through other means does not

excuse the Defendant from having to comply with the statutory mandate.. 19

V. The Trial Court should not have denied Harrell's request for attorney's fees and costs. 20

A. The degree of the parties' culpability or bad faith 21

B. Ability of the opposing party to pay an attorney's fee award 22

C. Whether a fee award will act as a deterrent 23

D. The Plaintiff's claim does involve a novel question concerning ERISA law, and an important one, as the issue is not limited to the specific fact pattern in this case. 23

E. The Trial Judge erred in considering the Plaintiff to have been unsuccessful on the merits of the case. 24

CONCLUSION 25

TABLE OF AUTHORITIES

Cases

Booth v. Wal Mart Stores, Inc., 201 F.3d 335 (4th Cir. 2000). 6,12,22

Bynum v. Cigna Healthcare, 287 F.3d 305 (4th Cir. 2002). 13

Davis v. Featherstone, 97 F.3d 734, 737-38 (4th Cir. 1996). 19

Elliot v. Sara Lee Corporation, 190 F.3d 601 (4th Cir. 1999) 10

Ellis v. Metropolitan Life Ins. Co., 126 F.3d 228, 232 (4th Cir. 1997) 8

Gooden v. Provident life & Accident Ins. Co., 250 F.3d 329, 335 (5th Cir. 2001) 11

Quesinberry v. Life Ins. Co. of North America, 987 F.2d at 1029. 21

Sedlack v. Braswell Services Group, Inc. 134 F.3d 219 (4th Cir. 1998) . . . . 15,16,17,18,19 , 20,21

Salley v. Dupont, 966 F.2d 1011 (5th Cir. 1992). . . 9

Wheeler v. Dynamic Eng'g, Inc., 62 F.3d 634, 638 (4th Cir. 1995). 13

Statutes

28 U.S.C. 1254(1) 1

28 U.S.C. 1446 1

28 U.S.C. 1291 1

29 U.S.C.(s) 1024(b)(4) . . . 2,15,16,17,23

29 U.S.C.(s) 1132 (c) . . . 2,5,14,15,17,19,20

29 U.S.C.(s) 1132(g)(1) 2,20

Rules

Rule 30(b)(6), F.R.C.P. 6

Other Authorities

29 C.F.R. Section(s) 2520.104b-1 (b) (2). . 20

OPINIONS BELOW

The Court of Appeals wrote an unpublished Opinion in this case, affirming based on the reasoning in the District Court Judge's Orders filed on January 15, 2003, January 21, 2003, May 14, 2003, and May 15, 2003. A copy of the unpublished Opinion is included in the Appendix, as are the Orders of January 15, 2003, January 21, 2003, May 14, 2003, and May 15, 2003 from the District Court.

JURISDICTION

On February 2, 2004, the Appeals Court for the Fourth Circuit affirmed the District Court's denial of Mr. Harrell's Motion for Reconsideration. This Court Has Jurisdiction under 28 U.S.C. 1254(1).

CONSTITUTIONAL PROVISIONS AT ISSUE

None.

STATUTORY PROVISIONS AT ISSUE

The questions presented implicate the following provisions of the U.S. Code:
29 U.S.C.(s) 1132 (c)
29 U.S.C.(s) 1132(g)(1)
29 U.S.C.(s) 1024(b)(4)

Whether discovery requests from a plan participant's attorney satisfy the requirement of a "written request" under 29 U.S.C. sections (s) 1024(b)(4).

STATEMENT OF THE CASE

Prior to December of 1996, Leon Harrell, the Appellant, was a Cardiac Catheterization Lab Technician at Carolinas Hospital in Florence, S.C. He began to suffer from a degenerative disease called Sarcoidosis. Harrell applied for short term disability benefits, and then applied for long term disability benefits in 1996. Pam Ward was a disability specialist for the Appellees. Ms. Ward made a final decision to deny Harrell's benefits on May 15, 1998. In the denial letter, she stated, as the reason for the denial, that the record contained no specific limitations supporting total disability, and that the medical information presented failed to document evidence of a medical condition that would render Harrell disabled under the plan definition. However, the record did, in fact contain medical evidence

supporting a finding of disability, and no evidence to the contrary. After the trial of this case (it was tried by written brief), Judge Houck found that Ms. Ward's decision was arbitrary, and awarded the Plaintiff damages based on her bad faith denial of the claim. Harrell appealed Ward's arbitrary decision. As Judge Houck recognized, the denial from Ward hobbled his efforts to get further medical assessments, as the money for treatment had been discontinued. Harrell's doctor, Dr. Booth performed a medical exam on Mr. Harrell, and wrote a report, which Harrell submitted to the Board, stating that Harrell was disabled to the point that he could not perform his job, that his medications had been increased, and that, due to Sarcoidosis, Harrell was unable to perform any meaningful work. Harrell, who had recently been approved for Social Security Disability benefits, also gave the committee his vocational assessment records, and the finding of disability by the Social Security Administration. The Appeals committee denied Harrell's appeal, on the basis that Harrell had failed to submit further medical evidence. Though Judge Houck found that Ms. Ward's decision to deny Harrell's benefits was unjustified and an abuse of discretion, and, in fact imposed liability on the Appellees for that decision, he decided that the appeals committee's affirmation of that decision was not an abuse of discretion.

Harrell had also requested a monetary award based on the Appellees' failure to produce

a copy of the plan within 30 days of a written request for the plan by his attorney, via a discovery request. The Court denied this request, ruling that a discovery request from an attorney does not satisfy the statutory burden necessary for the award of damages.

Finally, Mr. Harrell requested attorney's fees and costs, which are potential awards under the ERISA statute. The Court denied his request, through an analysis which is discussed below.

REASONS FOR GRANTING THE WRIT OF CERTIORARI

THIS COURT SHOULD GRANT CERTIORARI TO DETERMINE WHETHER, IN ERISA CASES, THE AFFIRMATION BY AN ADMINISTRATOR, OF A LOWER DECISION BY AN ADMINISTRATOR, WHICH WAS AN ABUSE OF DISCRETION AS A MATTER OF LAW, MUST ALSO BE CONSIDERED AN ABUSE OF DISCRETION.

THE COURT SHOULD GRANT CERTIORARI TO DETERMINE WHETHER, IN ERISA CASES, A DISCIVERY REQEST FOR A COPY OF THE PLAN, FROM A PLAN PARTICIPANT'S ATTORNEY CONSTITUTES A WRITTEN REQUEST FOR THE PLAN, SUCH THAT A FAILURE TO PRODUCE THE PLAN WITHIN THE 30

DAYS PROSCRIBED BY 29 U.S.C. (s) 1132(C) WOULD TRIGGER AN AWARD OF PENALTIES.

THE COURT SHOULD GRANT CERTIORARI TO DETERMINE WHETHER, THE GRANTING OF JUDGMENT ON THE ISSUE OF LIABLITY IN AN ERISA CASE QUALIFIES AS A DETERMINATION THAT PLAINTIFF HAS SUCCEEDED ON THE MERITS FOR THE PURPOISES OF AN ATTORNEY'S FEE AWARD.

THE COURT SHOULD GRANT CERTIORARI TO DETERMINE WHETHER THE ISSUE OF WHETHER DISCOVERY REQUEST, REQUSETING THE PLAN DOCUMENTS, SENT TO THE PLAN ADMINISTRATOR BY THE PARTICIPANT'S ATTORNEY CONSTITUTE A WRITTEN REQUEST FO RTHE PLAN UNDER 29 U.S.C. (s)1132(c) IS A NOVEL ISSUE OF LAW, THE DETERMINATION OF WHICH COULD BE IMPORTANT TO FUTURE PARTIES.

I. **The Court should have considered the evidence in the record which shows that Pam Ward and the Appeals Board were employees of CNA Insurance Companies, creating a conflict of interest.**

The Court, in its Order of January 16, 2003, considers this case under an abuse of discretion standard, rather than the conflict of interest evaluation under Booth v. Wal Mart Stores, Inc., 201 F.3d 335 (4th Cir. 2000), noting that the Appellant did not argue conflict of interest in the Brief that was submitted in September of 2000. From the testimony and evidence before the Court, it is clear that a conflict of interest, as contemplated under the ruling from Booth v. Wal Mart Stores, Inc., 201 F.3d 335 (4th Cir. 2000), existed in this case.

The Decision in Booth v. Wal Mart Stores, Inc., 201 F.3d 335 (4th Cir. 2000) actually requires the Court to consider whether there is a conflict of interest or not as part of its inquiry into the case. The "conflict of interest" argument is not a separate cause of action. Under Booth v. Wal Mart, a standard was created for the Court to use in considering liability in ERISA cases. The Appellant argues, therefore, that the Court was under a duty to apply this standard, to affirmatively investigate, and include, in its consideration of this case, any evidence presented to it, which would show such a conflict of interest. In Ms. Ward's Deposition, produced as an exhibit to the Harrell's Brief filed in September of 2000, it is clear that she is being deposed as a 30(b)(6) witness for CNA Insurance, representing that company. (Rule 30(b)(6), F.R.C.P.) She also admits, on page 9 of her

deposition, that she was employed as a disability specialist with the Company when she made the decision to deny Mr. Harrell's application for benefits under the plan. The Court, in its Orders of January 16th and May 14th, found this decision to be an abuse of discretion.

The appeals board, which reviewed Ms. Ward's decision was also was part of CNA Insurance. There is no dispute over the fact that CNA is the same company that would have paid benefits to Harrell had Ms. Ward not abused her discretion and decided to terminate Mr. Harrell's benefits. This is proof of a conflict of interest, clear proof of the exact type of conflict of interest that the Booth Court contemplated when it required Courts to apply the less stringent conflict of interest test to decisions made under these circumstances. The U.S. District Court erred, as a matter of law, in failing to apply the less stringent standard to this case. Had the Judge applied the correct standard, the outcome of the case would most likely have been different. The appeals committee reviewing a decision which was unquestionably an abuse of discretion should have been found liable for adopting and continuing this abuse of discretion, especially where a conflict of interest existed, and the Appellees benefited financially and directly from the decision. Thus, this error of law was not harmless, and should form a proper basis for a reversal of the District Court's ruling.

II. The evidence upon which the Appeal Board relied in deciding that there was no objective medical evidence submitted concerning Harrell's disabled status does not meet the "substantial evidence" standard set forth in Ellis v. Metropolitan Life Ins. Co., 126 F.3d 228, 232 (4th Cir. 1997).

In Ellis v. Metropolitan Life Ins. Co., 126 F.3d 228, 232 (4th Cir. 1997), the Fourth Circuit set forth the controlling law concerning the standard for deciding whether an administrator's decision was "reasonable." For the decision to be considered reasonable, it must have two elements, 1) it must be the result of a deliberate, principled reasoning process, and 2) it must be supported by substantial evidence. The appeal board's decision was not based on a deliberate reasoning process, nor was it supported by substantial evidence.

The record shows that the Board did not apply a deliberate principled reasoning process to Harrell's appeal. Instead, it simply and unreasonably discounted and refused to accept Dr. Booth's medical examination of the Plaintiff and the report thereon as medical documentation, regardless of the fact that it was clearly a report equal to the type of report that its own physician would have been able to render under the plan's rules. The Plan allows the administrator's doctor to perform a "physical examination" of the applicant. It is only reasonable to believe that this

process would have some reason behind it, that the Board could consider the report and findings from such a "physical examination" as medical evidence sufficient to refute or support findings by the applicant's doctor. In any deliberate and principled reasoning process, the board would have at least deliberated on or subjected a doctor's report from a physical examination to some kind of reasonable consideration or scrutiny. Instead, it dismissed it out of hand.

Finally, there is no substantial evidence to support a finding that Harrell was not disabled. In fact there is no such evidence whatsoever. Where the administrator decides to go forward with a decision based only on one doctor's findings, it must accept the findings and conclusions of the one treating physician. The U.S. District Court found, citing Salley v. Dupont, 966 F.2d 1011 (5th Cir. 1992), that Ms. Ward was not entitled to ignore Dr. Booth's indication that Harrell was disabled. The Appeal Board, under the same rationale, may not simply ignore Dr. Booth's subsequent letter and report, especially when the report was based on an actual physical examination of Harrell, where there are no conflicting reports, and where the Defendant had chosen not to take advantage of its policies allowing their own doctor to do a parallel examination.

In cases where the Court did find substantial evidence to support the administrator's decision, the facts indicate that there were conflicting reports, and at least *some*

evidence directly supporting a "no-disability" finding. In Elliot v. Sara Lee Corporation, 190 F.3d 601 (4th Cir. 1999), the Court declined to apply the SSA "treating physician" rule to ERISA cases. That case, however, is clearly distinguishable from this one. The "treating physician rule requires the fact finder to give great deference to the testimony of a treating physician who has treated the patient over a long period of time, and requires an award of benefits where there is no contradictory evidence. In that case, the Court declined to consider applying this rule, not because it was an ERISA case, but because there were five other doctors on record, disagreeing with Elliot's physician. In Harrell's case, however, even if the treating physician rule is not applied, common sense leads to only one workable conclusion. If there is only one doctor, only one set of findings, and no contradictions (the only contradictory findings came from Ms. Ward, and that determination has already been determined, by the Court, to have been an abuse of discretion) how can there be a determination that the one set of medical findings I the record, based on direct physical examination, are wrong, without an abuse of discretion?

III. The Appeals Board's refusal to recognize Dr. Booth's report concerning a medical examination of Harrell on May 21, 1998 as "objective Medical evidence" upon which it could make a determination of disability renders other language in the plan meaningless.

In the Order of January 16, 2002, the Trial Judge based his decision that the appeal board had not engaged in an abuse of discretion on the finding that "Plaintiff, however, did not supply CNA with any medical evidence supporting his claim for continued disability, but instead attempted to gain reversal of CNA's denial of benefits by a phone call and a letter from Dr. Booth."(Order of 1-16-02, p. 9) The Judge, in reaching this decision, relied on Gooden v. Provident life & Accident Ins. Co., 250 F.3d 329, 335 (5th Cir. 2001), finding that Defendant is entitled to deny benefits where it requested medical records and the insured refused to provide them. In this case, however, the Gooden decision, from the fifth circuit, should not apply because Mr. Harrell did, in fact, provide medical documentation in support of his appeal, in the form of a medical examination and the report thereon from Dr. Both. (a letter of June 1, 1998) Dr. Booth had performed a medical examination of Mr. Harrell on May 21, 1998. The June 1, 1998 letter, from Dr. Booth, which the Court recognizes as having been before the Board at the time of its decision, is medical evidence. When a

licensed, Medical Doctor conducts a medical examination of a patient, physically, and gives a report on his findings and conclusions, such a report should be considered objective medical evidence. If a licensed physician's diagnosis and prognosis, given after a physical medical examination of a patient is not to be considered medical evidence, what is?

In Booth v. Wal-Mart, 201 F.3d 335 (4th Cir. 2000), the Court recognized a plethora of factors that must be considered in deciding whether an abuse of discretion occurred. One of the elements requires the Court to consider whether the administrator, in applying the plan to reach its denial decision, had applied the plan terms consistently. The standard is whether the challenged interpretation might render some language in the plain documents meaningless or internally inconsistent. Id. The Appellee's rejection of Dr. Booth's letter of June 1, 1998, reporting the findings, outcomes, and conclusions from a physical medical examination of Harrell as objective medical evidence upon which the appeals board could make a decision would be directly at odds with the provision of the plan applying the administrator's doctor to perform a "physical examination." If one doctor's report from a physical examination is meaningless, then, to be consistent, the board would have to reject any doctor's report based on physical examination as medical evidence. This would require the administrator to discount any report from its own physician as well (had it chosen to

use this policy), and render the provision allowing physical examination by its own doctor meaningless.

The Plan includes a section entitled "DEFINITIONS" which defines terms used in the plan documents. This section does not define "objective medical evidence" as opposed to "subjective" or "non-objective" medical evidence. The Fourth Circuit has decided that "When interpreting an ERISA health insurance plan, we utilize and apply ordinary principals of contract law, and we 'enforce the plan's plain language in its ordinary sense.'" Wheeler v. Dynamic Eng'g, Inc., 62 F.3d 634, 638 (4th Cir. 1995). When, however, a term use is ambiguous, that ambiguity is construed against the drafter of the plan, and it is construed in accordance with the reasonable expectations of the insured. Id." Bynum v. Cigna Healthcare, 287 F.3d 305 (4th Cir. 2002). In this case, the term "objective medical evidence," in light of other provisions in the plan, would include a written report from a medical doctor, reporting the findings, diagnosis, and prognosis of a patient based on a "physical examination." Specifically, the plan does allow for the administrator to have its own doctor perform a "physical examination" of the applicant as many times as the administrator wishes. It only stands to reason that this provision is included so that the administrator's doctor's report, after a physical examination (just like the one Dr. Booth performed) can be relied on as medical evidence from which the administrator can make a

decision. Therefore, the plan document, on its face must either recognize Dr. Booth's letter concerning a physical medical examination of Harrell on May 21, 1998 as acceptable objective medical evidence, or present a useless and meaningless provision, allowing an examination by its own doctors, but rendering it useless as a basis for consideration of a claim.

To find one such report acceptable as medical evidence, but the other unacceptable is irreconcilable, absent inconsistent application of the policies. The Court has already found that Dr. Booth's letter of June 1, 1998 was before the Board when it made its decision. As the letter was based on an examination which occurred after April 13, 1998 (the last date that the Appellees had received medical documentation before denial of Benefits), it is objective medical evidence of Harrell's disability, which was submitted ***after*** the decision to deny, and in support of the appeal. As the Harrell ***did*** present this evidence, it ***was*** an abuse of discretion to deny his appeal based on a finding that there was no objective evidence in the record to support a finding of disability.

IV. Plaintiff requests reconsideration of the Court's findings and decision concerning an award under 29 U.S.C. (s) 1132 (c)

A. Discovery requests should be considered a "written request under 29 U.S.C. (s) 1132 (c)."

There is little or no case law on the issue of whether discovery requests from a plan participant's attorney satisfy the requirement of a "written request" under 29 U.S.C. sections (s) 1024(b)(4). It does seem clear that the sole act of service of a Complaint upon the Administrator, commencing a lawsuit, may not suffice. This makes sense, as a Complaint requires an Answer, affirmation or denial of the allegations in the Complaint, and is not a request for information. Discovery requests, however, are much different. The Fourth Circuit has recognized that a written request from an attorney, on behalf of a plan participant, is considered a "written request" under the statute. Sedlack v. Braswell Services Group, Inc., 1234 F.3d 219 (4th Cir. 1998). The request for the plan description, in this case, came from Harrell's attorney. It was a discovery request. The first one, anyway, may have been dated three days after the close of discovery. However, on its face, it is a written request for a copy of the plan from a plan participant. In Sedlack, the Court correctly recognized that the statute is plainly written, and not open for much interpretation. All it requires is that the plan participant (which would include Harrell, under the Court's analysis in Sedlack) submit a written request for the materials. The Plaintiff's first set of discovery requests, submitted in May of 1999

should suffice, under the plain language of the statute. As the Judge noted in his Order, this issue may be a novel question for the Court. The Appellant respectfully submits that, possibly, the reason that there is no case law on the subject of whether discovery requests fulfill the definition of a written request under 29 U.S.C. (s) 1024(b)(4) is that the statute is so plainly written and that a request for production of documents so clearly meets the criteria of a "written request," that there ***should*** be no question as to whether the Plan Participant should prevail on the issue. The Court erred, as a matter of law, in determining that Harrell had not made a written request to the Appellees for a copy of the plan.

B. Delay in judicial proceedings without legal justification is recognized as prejudicial under the Federal Rules of Civil Procedure.

The Trial Judge found that Harrell was not prejudiced by Appellee's groundless refusal to produce the plan in this case. In the Sedlack case, the administrator claimed that it saw "privacy issues" in handing a plan over to an unknown attorney, though this excuse was rejected by the Court. Whereas, in this case, the Appellees have not asserted a justification for their refusal to produce a copy of the plan. Under the Federal Rules of Civil Procedure an unjustified motion, or action, taken for the purposes of delay is an offense that could warrant sanctions from the Court. Rule 11 of the Federal Rules of Civil

Procedure affirmatively prohibits an attorney from actions which are taken for the purpose of delaying a proceeding. The Courts are allowed to impose sanctions for discovery abuses, mainly because a delay in production of information, which hinders ongoing discovery, is considered to be, per se, prejudicial to a party's attempts to prosecute or defend a case. The statute, under which the Plaintiff is requesting an award (29 U.S.C. (s) 1024(b)(4) and 29 U.S.C. (s) 1132 (c)) grants damages, on its face, based solely on the timing of the administrator's response to a request in writing for the Plan documents. It does not mention that any further inquiry is necessary or even desirable. In this case, the Appellees have never offered any reason or justification at all for not producing the plan. In Sedlack, the administrator gave, as a justification, that it did not know if the attorney requesting the documents on Sedlack's behalf was actually representing him. The Defendant, in that case claimed that it was justified in refusing to respond to the attorney's written request as a measure taken to protect the privacy of the plan participants. This justification was rejected by the Court, as was the Defendant's assertion that it had denied the request "only once." The Court correctly noted that "This argument must fail as nothing in the statute requires that more than one request be made before penalties may be imposed. See 29 U.S.C. (s) 1132(c)." Id. The Appellees' delay in producing the plan is prejudicial, especially considering the fact that

litigation was ongoing during the pendency of the request. The simple fact that the discovery period was over by three days at the date of the first written request does not change the fact that the written request was made, nor does it excuse the Appellees from the duty to respond under the statute.

C. Refusal to produce the Plan during discovery is proof of bad faith

In Sedlack, the Court specifically took into consideration the fact that the Defendant refused to produce the Plan in response to the Plaintiff's requests for production. In this case, the Plaintiff made three requests. The first was on May 4, 1999, the second (though admittedly three days beyond the end of the discovery period), on October 4, 1999, and the third on April 10, 2000 (within the discovery period of a new scheduling Order.) The Defendant did not produce the Plan documents until May 9 2000 (the transmittal letter was dated 5-9-00). Refusing to produce the Plan in response to the Plaintiff's first requests for production, and then only producing it after being sued for damages for the lack of production should be considered as prejudicial and evidence of bad faith on the part of the Appellees.

D. A showing of prejudice is not a requirement for the imposition of sanctions under Sedlack.

In Sedlack v. Braswell, the Fourth Circuit, citing to an earlier case in which the issue was addressed, confirms that a finding of prejudice is not essential to form the basis of the imposition

of the penalty under 29 U.S.C. (s) 1132(c). "Although prejudice is a pertinent factor, 'it is not a prerequisite to imposing a penalty.' Davis v. Featherstone, 97 F.3d 734, 737-38 (4th Cir. 1996)." Sedlack v. Braswell Services Group, Inc. 134 F.3d 219 (4th Cir. 1998). Even if the Court were correct in finding that there was no prejudice to the Appellant, from the Appellee's refusal to produce the plan this should not have been fatal to a request for damages under the statute.

E. That Harrell could have obtained the plan through other means does not excuse the Defendant from having to comply with the statutory mandate.

The Trial Judge gave, as one reason for denying Appellant's request for an award under 29 U.S.C.(s) 1132(c), that the Plaintiff had other means of obtaining the plan description as the case had been filed and discovery was proceeding. In fact, however, at the time the first written request was made, the discovery period had lapsed by three days. But for the fact that the parties had agreed to request an extension of the discovery period, the Plaintiff would ***not*** have had this opportunity. Furthermore, the Fourth Circuit has already rejected the argument that, because other means of access to the plan were available to the plan participant, the administrator is excused from its duties to produce a copy of the plan documents upon written request. In Sedlack v. Braswell Services Group, Inc. 134 F.3d 219 (4th Cir. 1998), the Defendant asserted

that "contrary to the district Court's conclusion that it did not provide a copy of the plan until February 29, 1996, the opportunity to copy the plan was made available to Sedlack no later than January 29, 1996." The Court made short work of this excuse, once again, referring to the clear language on the face of the statute "The applicable regulations, however, required Braswell to provide a copy of the Plan, not merely to make it available for copying. See 29 C.F.R. Section(s) 2520.104b-1 (b) (2)." Id. The Trial Judge erred in finding that the fact that the plan may have been available through "other means" bars imposition of the penalties called for in 29 U.S.C. (s) 1132(c).

V. The Trial Court should not have denied Harrell's request for attorney's fees and costs.

When considering a request for an award of attorney's fees under ERISA, the Court applies five factors. In this case, the U.S. District Court Judge should have found that, under the applicable five factor test, Mr. Harrell was entitled to recover attorney's fees under 29 U.S.C. (s) 1132(g) (1). The five factors are:

(1) The degree of opposing parties' culpability or bad faith;

(2) The ability of opposing parties to satisfy a fee award;

(3) Whether a fee award against the opposing parties would deter other persons acting under similar circumstances;

(4) Whether the parties requesting attorney's fees sought to benefit all Participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA itself; and

(5) The relative merits of the parties' positions.

Sedlack v. Braswell Services Group, Inc. 134 F.3d 219 (4th Cir. 1998) citing Quesinberry v. Life Ins. Co. of North America, 987 F.2d at 1029.

A. The degree of the parties' culpability or bad faith

The Trial Judge weighed this factor in favor of the Appellees. This is inconsistent with the fact that the trial judge clearly found the Appellees culpable. The Court granted the Appellant damages, finding that the decision to deny benefits was an abuse of discretion. The trial Judge also specifically recognized that Ms. Ward's abuse of discretion did, in fact, prejudice the Plaintiff from being able to seek further treatment or testing through which he could more effectively have fought his appeal. It should be a common sense conclusion that, but for the abuse of discretion in terminating Harrell's benefits, Harrell would not have even been in the position of appealing at all.

The first factor requires a determination of bad faith **OR** culpability. The Court, by giving a verdict in the Appellant's favor, certainly found that the Appellees are culpable.

As to bad faith, the finding of such an abuse of discretion, with the foreseeable

consequences (that Harrell would be in a position to have to appeal in the first place and in a position of not having access to medical treatment which could have affected his ability to effectively appeal) is evidence of bad faith. The appeals board's refusal to accept a report from Harrell's doctor based on a physical medical exam, where the Plan itself allows them to rely on their own doctor's report from a physical exam is also a clear indication of bad faith. Finally, the fact that the decision makers were also the ones responsible for paying out the benefits which had been denied indicates a level of bad faith. Booth v. Wal Mart Stores, Inc., 201 F.3d 335 (4th Cir. 2000)

The Trial Judge's finding that an abuse of discretion occurred in the decision to deny Harrell's benefits should also have not been ignored as an indication of a high degree of bad faith in this case. Abuse of discretion is not something that arises from a mistake, or misunderstanding. It refers to an intentional overstepping of ethical or moral boundaries, a knowing choice to take action that will result in harm to another person.

B. Ability of the opposing party to pay an attorney's fee award

The Trial Judge indicated that he declined to even consider this factor, claiming that there was nothing in the record to consider. Ignoring this factor is an error of law. There is evidence upon which the Court can base a decision on this

factor. The Court can certainly consider the actual amount of attorney's fees requested by the Plaintiff in determining whether a Defendant can pay them. Harrell requested a total of $6,900.00, an amount about equal to the amount of damages that the Trial Judge actually awarded in this case and probably less than damages including pre and post judgment interest that was awarded. The Appellees are in the Business of paying money. Clearly they have the capacity to pay out benefits in the amounts promised under the plan. If they did not, they could not operate. If the Defendant can afford to pay a monthly benefit of over $2,000.00 for years to plan beneficiaries, it can afford to pay attorney's fees equal to about three months worth of those benefits. This factor should have been weighed in favor of the Plaintiff.

C. Whether a fee award will act as a deterrent

The Court did properly weight this factor in favor of the Plaintiff.

D. The Plaintiff's claim does involve a novel question concerning ERISA law, and an important one, as the issue is not limited to the specific fact pattern in this case.

The Trial Judge acknowledged that the issue of whether discovery requests, requesting the plan, qualify as a "written request" for plan documents, for the purposes of 29 U.S.C. (s) 1024(b)(4) is a novel one. However, the Court

denies that it is an important issue. This is an erroneous decision. Any issue of law which has arisen once will arise again. If this is a novel question, and is one that may arise again, it should be considered an important one. It is important to address novel issues of law and resolve them one way or another, if, for no other reason, than to establish precedent on which others can rely. Precedent is the basis for most decisions by the Courts, but that precedent has to begin somewhere. The Trial Judge should have weighed this factor in Harrell's favor, and found that a novel question on an issue which is not restricted to one certain set of facts (this one would be applicable to any case in which such a written request for the plan through discovery is made) is an important one.

E. The Trial Judge erred in considering the Plaintiff to have been unsuccessful on the merits of the case.

The final factor requires the Court to consider the relative merits of the parties' positions. Though the Court clearly found that Harrell's allegations were proven, that the Appellees did abuse their discretion in denying his claim for benefits, the Court weighed this factor in favor of the Appellees. There is no escaping the fact that Harrell prevailed on the merits of the most important question in the case. But for the Appellees' abuse of discretion, Harrell would not even have had to face the burdens of the appeals board, or its own abuse of discretion and bad faith in refusing to accept his doctor's medical

evidence establishing his disability. This factor should have been weighed in Harrell's favor, as he ***did*** succeed on the merits of the case.

CONCLUSION

The affirmation of a decision which was an unjustified abuse of discretion should not escape the taint of the original wrongdoing. Review committees, and appellate systems are specifically designed to allow a second guess, a set of checks and balances to ferret out abuses, mistakes, or injustices in the system below the appellate level. The appellate committee in this case upheld an abuse of discretion with yet another abuse of discretion, by claiming that Harrell had not submitted medical evidence when he clearly did.

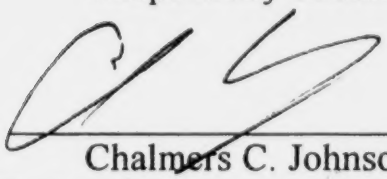
The Court should recognize a discovery request as a demand for documentation. That is the plain definition of a discovery request. To attempt to re-cast it as something other than a request from the represented party to the plan administrator simply denies the obvious nature of the action.

Finally, the specific facts and circumstances of this case to call for an award of attorney's fees and costs under ERISA. The Appellant respectfully requests that the Court issue an Order reversing the Trial Court's decisions on these three issues, and award Mr. Harrell damages for the loss of his benefits beyond the decision of the appellate committee, liquidated damages for the delay in producing the

plan, and attorney's fees and costs, as requested in the trial brief.

For the reasons set forth above, Petitioner LEON HARRELL respectfully prays that the Court grant a Writ of Certiorari to review the Judgment of the United States Court of Appeals for the Fourth Circuit in this case.

Respectfully Submitted,



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APPENDIX A – UNPUBLISHED OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT DATED AND DECIDED FEBRUARY 2, 2004

UNPUBLISHED

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 03-1698

LEON HARRELL,

Plaintiff – Appellant,

versus

CNA INSURANCE COMPANIES; CONTINENTAL CASUALTY COMPANY; QUORUM HEALTH GROUP, INCORPORATED I d/b/a Carolinas Hospital System; QHG OF SOUTH CAROLINA, INCORPORATED, d/b/a Carolinas Hospital System; CAROLINAS HOSPITAL SYSTEM GROUP LONG TERM DISABILITY PLAN,

Defendant - Appellees

Appeal from the United States District Court for the District of South Carolina, at Florence. C. Weston Houck, Senior District Judge. (CA-99-292-4-12)

Submitted: December 22, 2003 Decided: February 2, 2004

Before WILKINSON, MOTZ, and GREGORY, Circuit Judges.

Affirmed by unpublished per curiam opinion.

Chalmers C. Johnson, CHALMERS JOHNSON LAW FIRM, Charleston, South Carolina, for Appellant. John E. Schmidt, III, Kerry B. McTigue, NELSON MULLINS RILEY & SCARBOROUGH, L.L.P., Columbia, South Carolina, for Appellees.

Unpublished opinions are not binding precedent in this circuit. See Local Rule 36(c).

PER CURIAM:

Leon Harrell appeals the district court's orders denying his disability claim under the Employee Retirement Income Security Act of 1974, 29 U.S.C. SS 1001-1168 (2000), his request for sanctions under 29 U.S.C. § 1132, his requests for attorneys, fees and costs, and his request for reconsideration. We have reviewed the record and find no reversible error. Accordingly, we affirm for the reasons stated by the district court in its various orders. See Harrell v. CNA Insurance Co., No. CA-99-292-4-12 (D.S.C. filed Jan 15 and entered Jan. 16, 2003; Jan. 21, 2003; May 14, 2003; May 15, 2003). We dispense with oral argument because the facts and legal contentions are adequately presented in the materials before the court and argument would not aid the decisional process.

AFFIRMED

APPENDIX B – ORDER FROM U.S. DISTRICT COURT, JUDGE WESTON HOUCK, ENTERED JANUARY 16, 2003

JAN 15 2003
LARRY W. PROPES,

IN **THE UNITED STATES DISTRICT COURT**
FOR THE DISTRICT OF SOUTH CAROLINA
FLORENCE DIVISION

LEON HARRELL,	)	
Plaintiff,	)	**Civil Action No. 4:99-0292-12**
	)	
VS.	)	
	)	
CNA INSURANCE	)	
COMPANIES,	)	**ORDER**
CONTINENTAL	)	
CASUALTY COMPANY,	)	
QUORUM HEALTH	)	
GROUP, INC.,	)	
AND QHG OF SOUTH	)	
CAROLINA, INC., both	)	
d/b/a CAROLINA'S	)	
HOSPITAL SYSTEM	)	
GROUP LONG TERM	)	
DISABILITY PLAN	)	
Defendant.	)	
	)	

On December 16,1998, Leon Harrell ("Plaintiff') brought this claim in the court of common pleas for Florence County, South Carolina, alleging two causes of action against CNA Insurance Companies, Continental Casualty Company, Quorum Health Group, Inc., and QHG of South Carolina, Inc. ("Defendants"). Plaintiff alleged

causes of actions for termination of his benefits under 29 U.S.C. § 1132(a)(1) and for damages under 29 U.S.C. § 1132(c)(1) for violation of 29 U.S.C. § 1024(b)(4). On February 1, 1999, defendants removed the case to this Court. In their answer, CNA and Continental Casualty asserted a counterclaim for overpayment to plaintiff. On June3O, 2000-defendants moved for summary judgment on their counterclaim, and on July25, 2000, the Court granted the unopposed motion.

The parties subsequently agreed to try plaintiff's claims on submissions. After reviewing the exhibits, the evidence presented, and the briefs submitted by the parties, the Court makes the following Findings of Fact and Conclusions of Law.

I. FINDINGS OF FACT

1. Prior to December 1996, Plaintiff was a Cardiac Catheterization Lab Technician at Carolinas Hospital ("Carolinas")'m Florence, South- Carolina. Carolinas is owned by Quorum Health Group, Inc. and QHG of South Carolina, Inc. (collectively referred to as "Quorum").

2. Quorum contracted with Continental Casualty Company, known by· the trade name "CNA Insurance" ("C.IA") to provide an optional Long Term Disability program to its employees. Plaintiff purchased this insurance.

3. Under the insurance policy, "[t]otal disability" meant that because of injury or sickness [the employee] is

(1) continuously unable to perform the substantial and material duties of his regular occupation

(2) under the regular care of a licensed physician other than himself; and

(3) not gainfully employed in any occupation for which he is or becomes qualified by education, training, or experience.

4. The policy stated that "[the Administrator [Quorum] and other Plan fiduciaries have discretionary authority to interpret the terms of the Plan and to

determine eligibility for and entitlement to benefits in accordance with the Plan." CNA was a fiduciary of the policy.

5. In December 1996, plaintiff applied for long term disability benefits. He was suffering from osteomyelitus' of his left heel, sarcoidosis of his lungs and joints,' diabetes, high blood pressure, and depression. In support of his claim for disability, plaintiff submitted medical records, including test results and medical evaluations to CNA detailing his health problems. At that time he was being treated by Drs. Gary B. Anderson, a pulmonologist, and J.P. Booth, a family practitioner

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'Osteomyelitis is an inflammation of bone.

2Sarcoidosis is an inflammation of tissue.

6. December 18, 1996 was plaintiff's last day of work at Carolinas. Plaintiff's policy contained a 150-day elimination period. He was therefore not eligible to receive benefits until May 17, 1997.

7. On April 11, 1997, CNA notified plaintiff by letter that his claim for benefits had been approved. It also advised plaintiff that "[t]he policy requires that you... provide proof of ... continuing disability. Therefore, periodic claim reports will be sent to you.... To assure prompt payment of future benefits, please have the claim report completed as required and return it to us when requested."

8. Plaintiffs monthly benefit was 60% of his salary, or $2,342.08. This benefit, however, was subject to reduction by **the** amount CNA was entitled to withhold due to plaintiffs Social Security benefits. See Order of June 30, 2000.

9. Plaintiff s payments under the policy started on June 18, 1997. CNA appointed a disability specialist, Pam Ward, and a nurse case manager to review plaintiff's disability status on an ongoing basis.

10. At some point after his claim was approved, plaintiff stopped seeing Dr. Anderson, and instead relied on Dr. Booth to treat all of his infirmities and give updates to CNA. Dr. Booth submitted periodic reports and plaintiff continued receiving benefits until the spring of 1998.

11. In his April 13, 1998 report, Dr. Booth noted that plaintiff "has had significant lung disease in the past, but fortunately his [chest x-rays] have improved. He has problem [sic] with depression which is reasonably controlled." Dr. Booth also noted that plaintiff s progress had improved, but he increased plaintiff s dosage of Prednisone, the drug used to treat sarcoidosis, and

maintained his already-high dosage of Motrin. On CNA's disablity form, Dr. Booth checked "Yes" to the question "Is patient now totally disabled?" He checked "No" to the question that stated "Do you expect fundamental or marked change in the future?"

12. Upon reviewing the report, Ms. Ward and the nurse case manager, Ms. Teresa Barressi, determined that plaintiff no longer met the policy's requirement of total disability. On May 15, 1998, Ms. Ward sent a letter to plaintiff informing him that CNA no longer considered him disabled under the policy and explaining his rights to appeal. She stated that "[the medical information ... fails to document medical evidence of a continuously disabling physical or mental impairment that meets the definition of total disability. Verification that a medical condition exists does not confirm disability." The letter informed plaintiff of his right to appeal the decision and instructed plaintiff to send the appeals committee "objective medical information relevant to the issues and time period surrounding [his] claim."

13. On May 20, 1998, Dr. Booth, at plaintiff s request, called Ms. Barresi. Her notes of this conversation reveal that Dr. Booth stated that he was familiar with the requirements of plaintiff's job and that plaintiff could return to work. She also noted that Dr.

Booth agreed with Ms. Barresi's statement that returning to work would be therapeutic for plaintiff.

14. On May 21, 1998, plaintiff s application for disability with the Social Security Administration was approved. The Administration awarded plaintiff a lump sum of $17,120, resulting in defendants' overpayment to plaintiff for 1997-98 in the amount of $14,960.16.

15. On May 26, 1998, plaintiff notified Ms. Ward that he was appealing CNA's decision to

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3 Ms. Barresi was not the original nurse case manager on plaintiff s case but was assigned to his case sometime before May 1998.

stop his benefits. In a letter to plaintiff dated May28, 1998, Ms.Ward acknowledged the receipt of plaintiff's notice of appeal and forwarded plaintiff's file to CNA's appeals committee. This letter informed plaintiff that CNA had "not received medical documentation beyond [April 13, 1998]."

16. On June 1, 1998, Ms. Barresi faxed to Dr. Booth for his approval a confirmation and summary of their May 20, 1998 conversation. This summary stated (1) that Dr. Booth was familiar with plaintiffs job requirements, (2) that plaintiff's diabetes and blood pressure were well controlled, (3) that plaintiff s depression was under control, and (4) that it would be therapeutic for plaintiff to return to work.

17. Later that same day, Dr. Booth returned the taxed confirmation, but with significant modifications to Ms. Baressi's notes. He wrote that plaintiff s blood pressure and diabetes were "fairly" controlled, that plaintiff's depression "is not well controlled," and that it would only be therapeutic for plaintiff to return to work "if he could. He is not able to return to work at this time because of his depression [and]

inability to concentrate."' Dr. Booth also noted that his opinion had changed since May 20, 1998 and that he apologized for the inconvenience.

18. Dr. Booth also sent Ms. Barresi a letter dated June 1, 1998 informing her that he had e valuated plaintiff on May 21, 1998, the day after their earlier conversation. The letter states:

> Plaintiff continues to be significantly symptomatic from his sarcoid arthritis, his sarcoid shortness of breath and lung disease and depression. Unfortunately, he is unable to perform the duties of a cardiac catheterization lab technician largely due to his depression and his inability to concentrate and carry out his duties. It is felt that there would be undue risk to patients under his care.
>
> Fortunately, his depression has improved, but only somewhat. His medications have been increased to treat his depression.

---

4 This letter lists another reason why plaintiff could not return to work but the handwriting, ' '
is illegible

> Due to his sarcoid arthritis and his severe dyspnea,5 magnified by his sarcodosis, despite having relatively clear lung fields, he is unable to perform any heavy meaningful work.

19. All of the aforementioned correspondence was before the appeals committee. In addition, plaintiff submitted to the appeals committee a letter from the South Carolina Vocational Rehabilitation Center, a case synopsis of the Social Security adjudication officer, and a typewritten list entitled "Sarcoidosis and its Symptoms." He did not, however, submit further medical documentation.

20. On August 5, 1998, CNA's appeals committee notified plaintiff that his appeal was denied. The letter states that the reason for denial was the lack of objective evidence in the record that would verify plaintiff's status as totally disabled.

21. At no time before, during, or after the appeal did CAN order an in dependent examination of plaintiff as it was authorized to do under the policy.

22. On December 16, 1998, plaintiff filed suit against defendants, and on May 4, 1999, his attorney, Scott Kozacki, served a discovery request for production on defendants, including Quorum. In paragraph 8 of the request, plaintiff requested "[t]he governing Summary Plan Description(s) of Plaintiff's at issue [sic] long term disability claim." At no time prior to this request had plaintiff requested a copy of the plan in writing.

23. Mr. Kozacki subsequently stopped practicing law, and on August 20, 1999, the Court granted Mr. Kozacki's request to withdraw as counsel. On October 4, 1999, plaintiff, through his new counsel, Chalmers Johnson, served on Quorum a second request for production. In paragraph

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5 Dyspnea is abnormal or uncomfortable breathing.

3 of the request, plaintiff requested "any and all documentation provided to the Plaintiff by this Defendant outlining the provisions, terms, and conditions of The Carolina Hospital Systems Group Long Tern Disability Plan." The scheduling order then in effect, however, provided that discovery was to be closed on October 1, 1999. Quorum did not send plaintiff a copy of the plan.

24. A new scheduling order was later signed by the Court, and on April 10, 2000, plaintiff again served a request for production of the plan. On May 9, 2000,

Thomas W. McGee, attorney for defendants mailed a copy of the plan to Mr. Johnson.

II. CONCLUSIONS OF LAW

1. Plaintiff brought his claims in state court and defendant timely removed the action to federal court. The Court therefore has federal question jurisdiction over this ERISA claim pursuant to 28 U.S.C. §§ 1441 and 1331.

2. An insurance policy is governed by ERISA if it is maintained by an employer for the purpose of providing benefits for its participants Or their beneficiaries in the event of sickness, accident, disability, death or unemployment. See 29-U.S.C§1002. Plaintiffs policy is governed by ERISA.

3. The policy grants defendants discretion to determine eligibility for benefits. Plaintiff has made no real argument that defendants were operating under a conflict of interest, and the record appears to be silent on this point. The Court will therefore examine defendant's actions under an abuse of discretion standard of review. See Booth v. Wal-Mart Stores, Inc., 201 F.3d 335, 340-341 (4th Cir. 2000).

4. Under this standard of review, the Court will not disturb the administrator's or

fiduciary's decision if reasonable, even if the Court itself, upon examining the evidence, would have reached a different conclusion. See id. "[A] decision is reasonable if it is the result of a deliberate, principled reasoning process and if it is supported by substantial evidence." Ellis v. Metropolitan Life Ins. Co., 126 F.3d 228, 232 (4th Cir. 1997).

5. Ms. Ward's decision to terminate plaintiff s benefits was grounded on two interrelated reasons: (1) the lack of current medical documentation on file and (2) the supposed ambiguity in Dr. Booth's April 13, 1998 report.

6. With regard to the first reason, plaintiff submitted medical documentation in support of his initial

claim for disability. When it initially approved plaintiff for disability payments on April II, 1997, however, CNA instructed plaintiff that in order to maintain his classification of "disabled" under the policy, he needed to "have the claim report completed as required and return it ... when requested." It gave him no indication at that time that he would ever be required again to produce any documentation supporting his claim for disability other than the claim report, and he did not do so for the time period of 1997-98. CNA's decision on May 15, 1998 to deny plaintiff s further benefits based on the lack of medical documentation was therefore an abuse of discretion.

7. With regard to the second reason, Ms. Ward's denial of plaintiff's benefits was based on portions of Dr. Booth's report that favored terminating his benefits. She ignore ever, those portions of Dr. Booth's report that favored continuing plaintiff s benefits, the most important of which was Dr. Booth's determination that plaintiff was disabled. This decision, made without the benefit of an independent examination, was an abuse of discretion. See Salley v. Dppont, 966 F.2d 1011 (5th Cir. 1992) ("Because they chose to follow [plaintiff's physician's]

diagnosis, [the insurer was] required to follow all of his advice, not just part of it.").

8. On May 15, 1998, CNA requested medical evidence documenting plaintiff s condition. This request was appropriate. See Gooden v. Provident Life & Accident Ins. Co., 250 F.3d 329, 335 (5th Cir. 2001). An insurer must be allowed to hold plaintiff to his burden of proving he falls within the confines of the policy. Plaintiff, however, did not supply CNA with any medical evidence supporting Ms claim for continued disability, but instead attempted to gain reversal of CNA's denial of benefits by a phone call and a letter from Dr. Booth. CNA did not, therefore, abuse its discretion by ultimately denying plaintiffs benefits on August 5, 1998. See id. (finding no abuse of discretion upon termination where

insurer requested and insured did not provide medical records).

9. Plaintiff is not entitled to the equitable relief he requests under 29 U.S.C. § 1132(a)(3)-to be reinstated under the plan-because CNA did not ultimately abuse its discretion in terminating his benefits.

10. ERISA provides that "[t]he administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest UP dated summary plan description." 29 U.S.C. 1024(b)(4). It further provides that if the administrator fails to supply the requested information within 30 days, he may be liable, at the Court's discretion, to the participant in the amount of up to $100.00 per day. See29U.S.C.§1132(c)(1).

11. Complaints and requests for production are not "written requests [of administrators]" under the terms of § 1024(d)(4). See Verkullen v. South Shore Building and Mortgage Co., 122 F.3d 410 (7th Cir. 1997). Complaints are not "requests," and Courts are not "plan administrators." Id. And while requests for production directed at the administrator's attorneys

do request plans in fact, the purpose of § 1024(d)(4) is to "ensure that potentially legitimate claimants can get the information they need to determine whether they are in fact entitled to benefits." Davis v. Featherstone, 97 F.3d 734, 737 (4th Cir. 1996). Discovery requests, which are initiated only after insured's decide to assert their rights to benefits by suit, plainly do not further this goal.

12. Even if complaints and requests for production can be considered "written requests" for purposes of § 1024(b)(4), an award under that section requires an analysis of (1) prejudice to the plaintiff and (2) the defendant's bad faith. See Sedlack v. Braswell Services Group, Inc., 134 F.3d 219 (4th Cir. 1998); Davis 97 F.3d 737. There is no evidence in the record to support either prejudice or bad faith.

13. The Court may, in its discretion, award attorneys fees and costs under ERISA. See 29 U.S.C. § 1132(g)(1);

Quesinberry v. Life Ins. Co. of North America, 987 F.2d 1017,1028-29 (4th Cir. 1993).' Factors guiding the Court's discretion include:

(1) The degree of defendants' bad faith.
(2) The defendants' ability to satisfy an award of attorney's fees.
(3) Whether an award of attorney's fees would deter other persons from acting under similar circumstances.
(4) Whether the plaintiff s claim would benefit all participants and beneficiaries of the plan or resolve a significant legal question regarding ERISA itself (5) The relative merits of the parties' positions.

Id. at 1029. See also Reinking v. Philadephia American Life Ins. Co., 91 0 F.2d 1210, 1217-19 (4th Cir. 1990), overruled in part by Quesinberry, 987 F.2d 1017. There is no presumption that

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6 Quesinbegy dealt only with fees, not costs. But its five-factored approach interpreted § 1132(g)(1),the section that provides for both fees and costs. The Court will, therefore, apply Quesinberry's approach to costs as well as fees.

fees and costs are appropriate for a prevailing plaintiff. See Quesinberry, 987 F.2d at 1029. 14. The Court has found that CNA, through the actions of Ms. Ward, abused its discretion under the plan. The appeals committee, however, which sought only verifiable information regarding plaintiff s claim, did not abuse its discretion in affirming Ms. Ward's decision. It would have been wiser for CNA to allow plaintiff to continue receiving benefits for a reasonable time to allow him to gather medical records, but the Court does not think that CNA's actions support an award of fees.

15. The record is devoid of evidence regarding defendants' ability to pay an award of attorney's

fees. This Court will therefore not consider this factor in its fee analysis.

16. Any monetary Judgment against defendants will likely encourage them to counsel their employees either (1) clearly to inform their insureds what is required of them to maintain benefits or (2) give their insureds ample time to make such a showing once such a request is made. This factor weighs in plaintiff s favor.

17. Plaintiff's claims deal with no issues of great import to other potential plaintiffs. While plaintiff s second claim, that for damages under 29 U.S.C. § 1024(b)(4) for failure to produce plan documents pursuant to discovery requests, is relatively novel, potential plaintiffs' ability to obtain such documents through other means precludes the claim from being an important one. This factor too weighs in defendant's favor.

18. Plaintiff prevailed in part on one of his causes of action, and defendant prevailed on the other. Plaintiff s recovery, however, will be limited to the time after Ms. Ward's unlawful decision to terminate his benefits and before CNA's appeals committee decided plaintiff s claim. This factor also favors defendant.

19. Applying each factor, the Court determines that plaintiff is not entitled to attorney's fees. See Quesinberry, 987 F,2d at 1030 (upholding district court's denial of fee award where only one factor weighed in plaintiff's favor).

20. Plaintiff is, therefore, entitled to his $2,342.08 monthly payment for the time periods of May 18, 1998 to June 17, 1998, June 18, 1998 to July 17, 1998, and a pro rata amount of his payment for the 18-day time period from July 18, 1998 to August 5, 1998, for a total of $6,044.08.

21. ERISA does not provide for the award of pre-judgment interest, but the Court may grant such an award in its discretion. See Quenisberry, 987 F.2d at 1032. The interest rate is also left to the Court's discretion. See id. Because plaintiff was denied the use of these funds from the date of CNA's denial of his benefits, the Court will award plaintiff pre-judgment interest at the rate

prescribed in 28 U.S.C. § 1961 for use with post-judgment interest.'

AND IT IS SO ORDERED.

Weston C. Houck
United States
District Judge

January 14, 2003
Florence, SC

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7 Post-judgment interest is to be entered on the entire amount of plaintiff's recovery, including prejudgment interest. See Quenisberry 987 F.2d at 1034.

APPENDIX C– ORDER FROM U.S. DISTRICT COURT,
JUDGE WESTON HOUCK, ENTERED MAY 14 2003

FILED
MAY 14 2003
LARRY W. PROPES, CLERK OF COURT

IN **THE UNITED STATES DISTRICT COURT**
FOR THE DISTRICT OF SOUTH CAROLINA
FLORENCE DIVISION

LEON HARRELL,	)
	)
Plaintiff,	)**Civil Action No. 4:99-0292-12**
	)
VS.	)
	)
CNA INSURANCE COMPANIES,	) **ORDER**
CONTINENTAL CASUALTY COMPANY,	)
QUORUM HEALTH GROUP, INC.,	)
AND QHG OF SOUTH CAROLINA, INC.,	)
both d/b/a CAROLINA'S HOSPITAL	)
SYSTEM GROUP LONG TERM	)
DISABILITY PLAN	)
	)
Defendant.	)
	)

This matter is before the Court on the plaintiff's motion to alter or amend the Court's order of January 16, 2003. For the reasons that follow, the Court denies the motion.

On December 16, 1998, Leon Harrell ("Plaintiff') brought this claim alleging two causes of action against CNA Insurance Companies, Continental Casualty Company, Quorum Health Group, Inc., and QHG of South Carolina, Inc. "Defendants"). The plaintiff's causes of actions were for violations of 29 U.S.C. §§ 1132(c)(1) and (a)(1).

The parties agreed to try the case on submissions. OnJanuary16,2003,theclerk,entered an order containing findings of fact and conclusions of law whereby the Court (1) granted judgment to the defendant on the plaintiff's § 1024(b)(4) claim and (2) granted judgment to the plaintiff on his § 1 132(a)(1) claim, although the damage award was for an amount far less than what the plaintiff sought. On January 30. 2003, the plaintiff moved under Fed. R. Civ. P. 59(e) for the Court to alter or amend its January 16, 2003 order.' The plaintiff alleged that the Court erred by: (1) failing to consider the record in applying the abuse of discretion standard of review; (2) concluding the administrator's decision was reasonable; (3) finding that discovery requests are not "requests" as that term is used in § 1024(b)(4); and (4) failing to award attorney's fees.

A Rule 59(e) motion seeks an extraordinary remedy that district courts should use sparingly. See Pacific Insurance Co. v. American N itional Fire InLurance Co., 148 F.3d 396, 403 (4th Cir. 1998). Indeed, the Fourth Circuit recognizes but three grounds for a Rule 59(e) motion: (1) to accommodate an intervening change in controlling law; (2) to account for new evidence not available at trial; or (3) to correct a clear error of law or prevent manifest injustice. See id. at 402; EEOC v. Lockheed Martin Corp. 116 F.3d 110, 112 (4th Cir. 1997); Hutchinson v. Staton, 994 F.2d 1076, 1081 (4thClr. 1993). Theplaintiff's motion alleges that the Court's January 16,2003 order contains clear errors of law. The Court disagrees.

First. The plaintiff argues that the Court erred by failing to consider the record in applying the abuse of discretion standard of review. The January 16, 2003 order makes clear, however, that the Court did independently review the record despite the fact that the plaintiff made no argument in his trial

submissions that the defendants were operating under a conflict of interest. That order states:

> The policy grants defendants discretion to determine eligibility for benefits. Plaintiff has made no real argument that defendants were operating under a conflict of interest, and the record appears to be silent on this point. The Court will therefore examine defendant's actions under an abuse of discretion standard of review. See Booth v. Wal-Mart Stores, Inc., 201 F.3d 335, 340-341 (4th Cir. 2000).

Order of January 16, 2003 Section 11 at 1 3 (emphasis added). As this paragraph makes clear, the Court independently reviewed the record and found no conflict of interest. [2]

Second. The plaintiff argues that the Court erred by concluding the administrator's decision was reasonable. In particular, he first argues that CNA's decision did not comport with the procedural and substantive requirements of Ellis v. Metropolitan Life Ins. Co., 126 F.3d 228, 232 (4th Cir. 1997). Second, he argues that both the appeal board's and the Court's

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1 The plaintiff's motion is styled as a motion for reconsideration. The Federal Rules make no provision for such a motion. Instead, Rule 59(e) allow a party to bring a motion to alter or amend judgment. The Court will interpret the plaintiff s motion for reconsideration as a Rule 59(e) motion to alter or amend judgment.

failure to credit Dr. Booth's June 1, 1998 letter was in error.

With respect to the plaintiff s first argument, the Court has reviewed the record and determines again, and for the same reasons as stated in the January 16, 2003 order, that the appeals board's decision was reasonable. [3] With respect to the second argument, it is clear that both the appeals board and the Court examined 'Dr. Booth's letter. The letter, however, contained only conclusory statements unaccompanied by supporting evidence documenting the plaintiff's disability. It was not error to give little, if any, weight, to the letter. [4]

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[2] Moreover, while the plaintiff now argues for the first time that CNA had a conflict of interest because its appeals board was comprised of its own employees, he cites no law in support of this startling proposition. Cf Doe v. GroM Hospitalization & Medical Services, 3 F.3d 80, 86 (4th Cir. 1993) (conflict of interest exists where plan insurer is also its administrator and insurer/administrator therefore has incentive to deny claims).

[3] The plaintiff also argues the Court erred by failing to apply the treating physician rule. Notwithstanding the fact that Fourth Circuit has not adopted this doctrine, see Elliot v. Sara Lee Co., 190 F.3d 601 (4th Cir. 1999), given the ambiguities in Dr. Booth's report and the lack of medical evidence supporting the plaintiff s disability, its application would have made no difference in this case.

[4] The plaintiff also argues that the appeal board's decision not to credit Dr. Booth's letter rendered other plan provisions meaningless. In particular, the plaintiff argues that if the appeal board

can discount Dr. Booth's letter, it renders meaningless the provision allowing CNA to

Third. The Plaintiff argues that the Court erred by finding that discovery requests are not &requests" as that term is used in § 1024(b)(4). As the court in Verkuilen v. South Shore Building And Mortgage Co. noted, however, treating discovery requests as "requests" ignores the point that

> one must have a grievance before commencing suit; delay in responding to a ... discovery request can't logically be what the case is about. Unless the parties have a dispute predating the [discovery request], there is nothing to litigate about[:] unless the participant made a request in writing to the plan administrator more than 30 days before filing the complaint, there is no case or controversy; and if the written request was made, there is no need to treat the [discovery request] as a [§ 1024(b)(4)] request.

122 F.3d 410, 41@ 1 (7th Cir. 1997) (emphasis in original)., The Court's finding was not erroneous.5

Fourth. The plaintiff argues that the Court erred by failing to award attorney's fees. The Court has reconsidered its decision and again denies the request for an award of attorney's fees for the same reasons as announced in its January 16, 2003 order.

For the foregoing reasons, the plaintiff s motion is denied.

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conduct its own independent examination of its insureds. This argument, however, is without merit, for it presumes

that CNA's independent examination would necessarily produce nothing but an unsupported letter.

5 The plaintiffs other arguments regarding his § 1024(b)(4) claim are therefore rendered moot.

AND IT IS SO ORDERED.

C. Weston Houck
United States District Judge

May 14, 2003
Florence, SC

APPENDIX D – ORDER FROM U.S. DISTRICT COURT, JUDGE WESTON HOUCK, ENTERED JANUARY 16, 2003

FILED
MAY 15 2003
LARRY W. PROPES
CLERK OF COURT,
FLORNECE SC

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
FLORENCE DIVISION

LEON HARRELL,	)
	)
Plaintiff,	)**Civil ActionNo. 4:99-0292-12**
	)
VS.	)
	)
CNA INSURANCE COMPANIES, CONTINENTAL CASUALTY COMPANY, QUORUM HEALTH GROUP, INC., AND QHG OF SOUTH CAROLINA, INC., both D/b/a CAROLINA'S HOSPITAL SYSTEM GROUP LONG TERM DISABILITY PLAN,	))**AMENDED**)**JUDGMENT**)**IN A CIVIL**)**CASE**)))))
Defendant.	)

[ ] Jury Verdict. This action came before the Court for a trial by jury. The issues have been tried and the jury has rendered its verdict.

[X] Decision by Court. This action came before the Court on the parties agreement to try plaintiffs claims on submissions. The issues have been tried and a decision has been rendered,

IT IS ORDERED AND ADJUDGED that judgment is entered for the plaintiff Leon Harrell in the amount of Six Thousand, Forty-Four and 08/100 ($6,044.08) Dollars plus prejudgment interest at the rate prescribed in 28 U.S.C. § 1961 for the time periods of May 18, 1998 to June 17, 1998, June 18, 1998 to July 17, 1998 and July 18, 1998 to August 5, 1998 together with post judgment interest on the entire amount of plaintiff's recovery, including pre judgment interest.

IT IS FURTHER ORDERED that summary judgment having previously been granted on defendants' counterclaim, that defendants CNA Insurance Companies, Continental Casualty Company, Quorum Health Group, Inc., and QHG of South Carolina, Inc., both d/b/a Carolina's
Hospital System Group Long Term Disability Plan recover of the Plaintiff Leon Harrell Fourteen Thousand, Nine Hundred Seventy and 16/100 ($14,970.16) Dollars (the amount of Social Security Benefits received by plaintiff while he received benefits from CNA), plus interest in the amount of Four Thousand, Eight Hundred Eighteen and 91/100 ($4,818.9 1) Dollars and attorneys' fees in the amount of Two Thousand, Three Hundred Twenty-Four ($2,324.00) Dollars for a total of Twenty Two Thousand, One Hundred Thirteen and 07/100 ($22,113.07) Dollars, and this action is hereby dismissed.

LARRY W. PROPES, Clerk
By _____
Deputy Clerk

May 15, 2003

(2)

Supreme Court, U.S.
FILED
JUN 7 - 2004
OFFICE OF THE CLERK

No. 03-1507

In The
Supreme Court of the United States

LEON HARRELL,

Petitioner,

vs.

CNA INSURANCE COMPANIES; CONTINENTAL CASUALTY COMPANY; QUORUM HEALTH GROUP, INC. D/B/A CAROLINAS HOSPITAL SYSTEM; QHG OF SOUTH CAROLINA, INC. D/B/A CAROLINA HOSPITAL SYSTEM; CAROLINAS HOSPITAL SYSTEM GROUP LONG TERM DISABILITY PLAN,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fourth Circuit

RESPONDENTS' BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

Petitioner Leon Harrell's long term disability benefits were terminated first by the Plan's Case Manager and later by the Plan's Appeals Committee. The termination by the Case Manager was found by the District Court to be an abuse of discretion and reinstatement of benefits was awarded to Petitioner for that period of improper denial. In contrast, the District Court found the Appeals Committee's subsequent decision to also terminate Petitioner's benefits was proper. The Appeals Committee's decision was based on additional information, different from the information which served as the basis of the Case Manager's decision. The Appeals Committee's decision was not merely an affirmation of the Case Manager's decision. Petitioner asserts that because the Case Manager's decision was an abuse of discretion, the subsequent Appeals Committee's decision was also, as a matter of law, an abuse of discretion. This issue is not one on which this Petition should be granted. ERISA requires the Court to weigh each decision of termination of benefits against the abuse of discretion standard. The Court properly conducted this analysis and determined that the Appeals Committee's decision was proper. Prior to its decision, the Appeals Committee requested "objective medical information" in support of Petitioner's claim of permanent medical disability. Instead of objective medical information, Petitioner supplied a letter from his physician to the Appeals Committee which contradicted previously submitted medical records. Petitioner failed to submit any medical records at all in support of his appeal to the Appeals Committee. In such a case, the Appeals Committee appropriately decided to terminate benefits.

QUESTIONS PRESENTED – Continued

Petitioner's Questions 2 and 4 deal with whether a Request for Production filed in litigation can be considered a written request for plan documents under ERISA, 29 U.S.C. § 1132(c), thus triggering the statutory penalty for a failure to respond. This issue has been plainly decided by the 7th Circuit in *Verkuilen v. South Shore Bldg.*, 122 F.3d 410, 411 (7th Cir. 1997) ("An interrogatory under Fed.R.Civ.P. 33 [and a request for production of documents under Fed.R.Civ.P. 34] is a lawyer-to-lawyer device, rather than a participant-to-administrator device," and failure to respond to the discovery request has its own consequences.) The lower court here adopted the reasoning of that 7th Circuit decision and the 4th Circuit affirmed that decision. There is no other Circuit Court decision to the contrary. There is no reason for this Court to grant certiorari to decide this issue.

Finally, Petitioner seeks certiorari on the issue of whether Petitioner should have been awarded attorneys' fees. Petitioner bases his entitlement to attorneys' fees solely on the fact that the Court imposed liability and awarded damages on one of Petitioner's causes of action. Even though that is the issue presented by Petitioner, the facts set forth in the question do not accurately represent the facts of this case and the answer to that question is inconsequential because success on the merits is not a factor to be considered in awarding attorneys' fees under ERISA. The District Court properly applied the factors guiding the Court's discretion in awarding fees in ERISA cases. Success on the merits is not a factor in that analysis. Instead, the District Court is to consider the relative merits of the parties' positions. The District Court appropriately

QUESTIONS PRESENTED – Continued

and accurately applied this factor to the facts of this case. Because the Appeals Committee's termination was not an abuse of discretion, the District Court properly held that this factor weighed in favor of Respondents. This question presented by Petitioner does not present a novel issue or a split in circuit court decisions, nor does the Petitioner argue that different factors should have been considered by the Court in determining a fee award. The Court should not grant certiorari on this question or any of the other questions presented by Petitioner.

TABLE OF CONTENTS

	Page
Questions Presented for Review	i
Table of Contents	iv
Table of Authorities	v
Opinion and Judgment Below	1
Errors and Omissions in Petitioner's Statement of the Case	2
Reasons for Denying the Writ	8
Argument	9
I. The Appeals Committee's Discretionary Decision To Uphold The Termination Of Petitioner's Benefits Was The Result Of A Deliberate, Principled Reasoning Process And Is Not, As A Matter Of Law, An Abuse Of Discretion As A Result Of The District Court's Determination That The Case Manager's Decision To Terminate Benefits Was An Abuse Of Discretion	9
II. The Case Law On The Issue, Which The District Court Followed, Holds That Discovery Requests Cannot Be Considered A "Written Request" Under 29 U.S.C. § 1024(b)(4)	11
III. The District Court Properly Applied The Test For Awarding Costs And Attorney's Fees Under ERISA	12
Conclusion	14

TABLE OF AUTHORITIES

Page

CASES

Gooden v. Provident Life & Accident Ins. Co., 250 F.3d 329 (5th Cir. 2001) 9

Kamler v. H/N Telecom. Serv. Inc., 2001 U.S. Dist. LEXIS 21328 (N.D. Ill. June 25, 2001) 11

Quesinberry v. Life Ins. Co., 987 F.2d 1017 (4th Cir. 1993) 12

Verkuilen v. South Shore Bldg., 122 F.3d 410 (7th Cir. 1997) 8, 11

OTHER AUTHORITIES

29 U.S.C. § 1024(b)(4) 1, 11

29 U.S.C. § 1132, et seq. 1, 8, 11, 12

Webster's New Explorer Medical Dictionary (1999) 2, 3

OPINION AND JUDGMENT BELOW

Petitioner originally filed this action in the State Court for recovery of plan benefits under ERISA, and recovery for alleged violations of 29 U.S.C. §§ 1024(b)(4) and 1132(c). Respondents removed the case to the United States District Court for South Carolina, Florence Division. Respondents moved for summary judgment as to Respondents' Counterclaim that it was entitled to, as a matter of law, the amount representing the social security benefits received by the Petitioner while he was receiving benefits from Respondents. The District Court granted the Respondents' Motion.

The Parties agreed to the trial of this case by submission of briefs to the District Court. The District Court ruled that the Case Manager's decision to terminate benefits was an abuse of discretion, upheld the Appeals Committee's decision, and awarded the Petitioner the disability benefits that should have been paid between the Case Manager's decision and the Appeals Committee's decision.

Thereafter, Respondents moved for enforcement of the previously granted Summary Judgment Motion, and Petitioner moved for Reconsideration. The District Court denied Petitioner's Motion to Reconsider by Order dated May 14, 2003 and entered an Amended Judgment the following day. The Amended Judgment reflects that Petitioner was awarded Six Thousand, Forty-Four and 8/100 ($6,044.08) dollars, plus pre and post-judgment interest, in addition to and contrasted by the previous award to the Respondents, inclusive of attorneys' fees and interest, totaling Twenty-Two Thousand, One Hundred Thirteen and 07/100 ($22,113.07) dollars.

Petitioner timely filed a Notice of Appeal to the United States Court of Appeals for the Fourth Circuit on June 3, 2003. On February 2, 2004, the United States Court of Appeals for the Fourth Circuit affirmed the District Court's Orders.

ERRORS AND OMISSIONS IN PETITIONER'S STATEMENT OF THE CASE

Petitioner includes an abbreviated version of facts within the Statement of the Case and disperses various other factual statements throughout the argument. However, Petitioner misstates certain facts and fails to include all of the facts important to the Court's decision in this matter. These facts are set forth below.

Petitioner was a Cardiac Catheterization Laboratory Technician at Carolinas Hospital ("Carolinas") in Florence, South Carolina. Carolinas was owned and operated by Quorum Health Group, Inc. ("Quorum"). Quorum provided an optional Long Term Disability Program ("Plan") to its employees through CNA.

Petitioner suffered from osteomyelitis[1] of his left heel and underwent corrective surgery on January 7, 1997. After his surgery, Petitioner's physician estimated that he would be out of work for approximately two weeks.

[1] Osteomyelitis is defined as "an infectious inflammatory disease of bone often of bacterial origin that is marked by local death and separation of tissue." *Webster's New Explorer Medical Dictionary*, 485 (1999).

Petitioner's doctor later amended his expected return to work date to March 1, 1997.

The Plan covering Petitioner contained a 150-day elimination period. Accordingly, Petitioner was not eligible to receive benefits until May 17, 1997. On April 12, 1997, Petitioner submitted an additional Employee's Statement detailing his health problems. In his statement, Petitioner claimed he continued to suffer from osteomyelitis as well as sarcoidosis.[2]

On April 11, 1997, CNA notified Petitioner that his claim for benefits had been approved. It also advised Petitioner that a nurse case manager would be discussing Petitioner's progress with his doctor. Further, Petitioner was reminded that under the Plan, he had to "provide proof of your continuing disability." Lastly, Petitioner was informed that he would receive benefits of 60% of his monthly salary on the eighteenth of each month beginning June 18, 1997. In order to receive benefits, the Plan required Petitioner to meet the Plan's definition of "total disability." Under the terms of the Plan, Petitioner could receive twenty-four months of benefits if he was totally disabled from his own occupation. If Petitioner continued to be totally disabled beyond that benefits period, he would be eligible to continue receiving benefits only if he was unable to be " . . . gainfully employed in *any* occupation for

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[2] Sarcoidosis is defined as "a chronic disease of unknown cause that is characterized by the formation of nodules resembling true tubercles esp. in the lymph nodes, lungs, bones and skin – called also Boeck's sarcoid." *Webster's New Explorer Medical Dictionary*, 614-615 (1999).

which he is or becomes qualified by education, training or experience." (emphasis added).

Petitioner was paid his first monthly benefits check on June 18, 1997. Petitioner's doctors' diagnoses and the medical evidence supported a finding that Petitioner was totally disabled under the Plan at that time. A nurse, Terri Barresi, and a Case Manager, Pam Ward, were assigned to the case. Nurse Barresi and Ms. Ward continued to monitor Petitioner's progress and worked with his doctors in assessing Petitioner's improvement.

In September 1997, Nurse Barresi and Ms. Ward were advised by Petitioner's physician, Dr. J.P. Booth, that he expected Petitioner to return to work on October 1, 1997. Dr. Booth believed that "part time work would be great at this point" and suggested a transition back to full time work at Carolinas. Based on this information, Petitioner's benefits were set to be discontinued. However, after reviewing additional medical evidence, Nurse Barresi and Ms. Ward decided this new information supported the continuation of benefits to Petitioner. This is one example of how Respondents continued Petitioner's benefits as long as he met the criteria set forth in the Plan.

Benefits were paid to Petitioner through the Spring of 1998. Petitioner's physician, Dr. Booth, continued to provide Respondents with progress reports and to discuss the case with Nurse Barresi and Ms. Ward. Petitioner misstates in his statement of the case that the record did contain medical evidence of disability and no evidence to the contrary. In fact, the evidence to the contrary came in Dr. Booth's April 13, 1998 report in which he noted Petitioner's marked improvement. For example, the report

states that Petitioner's depression was reasonably controlled,[3] his heart sounded normal, lungs were clear and his blood pressure was within normal limits. Importantly, Dr. Booth's report did not contain any specific limitations supporting continuous total disability. Upon receiving the April 13, 1998 report, Nurse Barresi and Ms. Ward discussed the status of Petitioner's improvement. It was determined that Petitioner no longer met the Plan's requirement of total disability, but that he would be paid another payment "in good faith with a letter of termination." A termination letter was drafted by Ms. Ward ("Case Manager") and approved by Nurse Barresi. The letter was dated May 15, 1998, and was sent to Petitioner. The letter detailed the specific reasons for termination of benefits, explained his rights to appeal under the Plan, and urged him to submit additional evidence supporting his claim if he disagreed with the decision.

Petitioner received the May 15, 1998 termination letter on or about May 18, 1998, and called to speak with the Case Manager and Nurse Barresi. Petitioner also went to see Dr. Booth within two days of receiving the letter. Petitioner told Dr. Booth he was concerned that his benefits had been cut off.

About this time, on May 20, 1998, Dr. Booth spoke with Nurse Barresi about Petitioner's condition. During this conversation, Dr. Booth told Nurse Barresi that he was familiar with the type of work requirements of a

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[3] After Petitioner stopped working in December of 1996, he had bouts with severe depression which eventually required in-patient treatment at Greenland Park in October of 1997. Greenland Park is a psychiatric ward at McLeod Hospital.

Cardiac Catheterization Laboratory Technician and that it would be therapeutic for Petitioner to return to work. Further, Dr. Booth agreed that Petitioner's blood pressure, diabetes and depression were controlled and that his lungs were clear at his last examination. In sum, Dr. Booth echoed his findings detailed in his April 13, 1998 report and confirmed CNA's decision that Petitioner was no longer totally disabled.

On May 26, 1998, Petitioner notified CNA that he was appealing its decision to stop his benefits. In a letter dated May 28, 1998, CNA acknowledged the receipt of Petitioner's appeal and forwarded all additional documents and the file to the Appeals Committee, which is totally separate from the Case Manager and Nurse Barresi.

On June 1, 1998, Nurse Barresi sent a letter to Dr. Booth confirming their May 20, 1998 conversation in which Dr. Booth stated that "it would be therapeutic for Mr. Harrell to return to work." That same day, Dr. Booth faxed Nurse Barresi's letter back to her with handwritten notes retracting his May 20, 1998 opinions. In his retraction, Dr. Booth stated that Petitioner's depression was the cause of his being unable to return to work.[4] There is no mention of any limitations caused by osteomyelitis or sarcoidosis. It is important to note that between Dr. Booth's recommendation that Petitioner return to work

[4] Nonetheless, the May 21, 1998 OHA Psychiatric Review Technique Form submitted by Frederick W. Christianson indicates that Petitioner's depression and mental health results in only "slight" restrictions on activities of daily living and social functioning. This independent finding supports Dr. Booth's April 13, 1998 diagnosis and the May 15, 1998 decision to terminate Petitioner's benefits.

and his retraction, Petitioner visited Dr. Booth and expressed concern about losing his benefits.

In addition to his handwritten notes faxed to Nurse Barresi on June 1, 1998, Dr. Booth sent her a letter on June 1, 1998. In this letter, Dr. Booth wrote that Petitioner was "unable to perform any heavy meaningful work." However, Petitioner's job description states that the physical demands are "medium," not "heavy."

On August 5, 1998, the Appeals Committee notified Petitioner that his appeal had been denied. The letter gave very specific reasons for the Appeals Committee's decision. For example, the Appeals Committee noted lack of medical evidence supporting certain ailments, as well as the absence of specific test results and information that would verify Petitioner's claims of continued total disability. More specifically, the Appeals Committee noted that it had been over two years since an ACE[5] test detailing the status of Petitioner's sarcoidosis had been provided, that it had not been given objective medical evidence of Petitioner's sarcoid arthritis, nor was it provided with routine supporting criteria such as a report of the Global Assessment of Functioning Scale per the DSM IV[6] relating to claims of continued depression. Because there was no objective medical evidence provided to the Case Manager and the Appeals Committee that supported a finding that Petitioner was totally disabled, his appeal was denied. Petitioner misstates in his statement of the case that Dr.

[5] An angiotension-converting enzyme test determines the status and severity of sarcoidosis.

[6] Diagnostic and Statistical Manual of Mental Disorders.

Booth performed a medical exam on Petitioner after the denial by the Case Manager. No record of a medical examination was submitted to the Appeals Committee. Petitioner only submitted a letter from Dr. Booth that was conclusory and contradicted his previously submitted medical records.

REASONS FOR DENYING THE WRIT

There are no compelling reasons to grant the Petition for Writ of Certiorari in this case and many reasons to deny the Petition. In his Petition under the section entitled "Reasons for Granting the Writ of Certiorari," Petitioner sets forth all of his arguments on the merits. The only issue which could be construed as fitting within the purview of a compelling reason upon which this Petition could be granted is Petitioner's assertion that the issue of whether discovery requests can trigger liability under 29 U.S.C. § 1132(c) is a novel issue. Petitioner asserts that it is a novel issue because it is an issue that can occur again and it is important to future parties. However, the issue has been decided by the 7th Circuit which held that discovery requests cannot trigger liability under ERISA, 29 U.S.C. § 1132(c). *Verkuilen v. South Shore Bldg.*, 122 F.3d 410 (7th Cir. 1997). The trial court here ruled consistently with and in reliance on this 7th Circuit decision. No circuit court has issued a decision to the contrary. Therefore, this issue is not a novel issue requiring review by this Court.

The other issues presented by Petitioner for review do not present novel issues nor do they present circumstances

where there is a split among the circuits, nor any other compelling reasons requiring the grant of this Petition.

ARGUMENT

I. THE APPEALS COMMITTEE'S DISCRETIONARY DECISION TO UPHOLD THE TERMINATION OF PETITIONER'S BENEFITS WAS THE RESULT OF A DELIBERATE, PRINCIPLED REASONING PROCESS AND IS NOT, AS A MATTER OF LAW, AN ABUSE OF DISCRETION AS A RESULT OF THE DISTRICT COURT'S DETERMINATION THAT THE CASE MANAGER'S DECISION TO TERMINATE BENEFITS WAS AN ABUSE OF DISCRETION.

Petitioner's claim that the Appeals Committee's decision was an abuse of discretion as a matter of law because it affirmed, although on different information, the Case Manager's decision is unsupported by law or fact and Petitioner fails to provide any support for such a proposition. The Appeals Committee properly requested Petitioner to submit objective medical evidence in support of his appeal. *See Gooden v. Provident Life & Accident Ins. Co.*, 250 F.3d 329, 335 (5th Cir. 2001) (an insurer must be allowed to hold a claimant to his burden of proof as to whether the claimant fits within the policy's provisions.). Petitioner failed to meet this burden. He attempted to convince the Appeals Committee to reverse the Case Manager's decision with phone calls and letters from himself and his doctor, none of which were accompanied by any objective medical information. The lack of such objective medical evidence provided the basis for the Appeals

Committee's decision to uphold the denial of Petitioner's benefits.

Petitioner further alleges that the Appeals Committee refused to accept Dr. Booth's medical examination and report, presumably from Dr. Booth's letter of June 1, 1998, as medical documentation. Clearly, the Appeals Committee did consider this report. However, when considered along with Dr. Booth's previous statements, which weighed in favor of termination of Petitioner's benefits for disability, the Appeals Committee arrived at the reasoned, principled decision that the Petitioner had failed to provide the requisite objective documentation which supported his claim that he could no longer perform the duties of his occupation. Clearly, the decision of the Appeals Committee to deny Petitioner's disability benefits did not constitute an abuse of discretion.

There is no support for the issue on which Petitioner requests this writ be granted. The Appeals Committee's decision is not as a matter of law an abuse of discretion merely because the Case Manager's decision which it upheld was found to be an abuse of discretion. Each decision denying benefits was entitled to review by the Court. The Appeals Committee's decision was made by different people relying on different evidence and supported by different information than the decision made by the Case Manager. There is no de facto abuse of discretion and the Petition should not be granted.

II. THE CASE LAW ON THE ISSUE, WHICH THE DISTRICT COURT FOLLOWED, HOLDS THAT DISCOVERY REQUESTS CANNOT BE CONSIDERED A "WRITTEN REQUEST" UNDER 29 U.S.C. § 1024(b)(4).

The 7th Circuit has held that litigation discovery requests do not constitute a request for plan documents to trigger penalties under ERISA. "An interrogatory under Fed.R.Civ.P. 33 [and a request for production of documents under Fed.R.Civ.P. 34] is a lawyer-to-lawyer device, rather than a participant-to-administrator device," and failure to respond to the discovery request has its own consequences. *Verkuilen v. South Shore Bldg.*, 122 F.3d 410, 411 (7th Cir. 1997); *See also Kamler v. H/N Telecom. Serv. Inc.*, 2001 U.S. Dist. LEXIS 21328 (N.D. Ill. June 25, 2001). Indeed, "[n]othing but confusion could come from treating complaints and interrogatories as ERISA demands, and replacing [F.R.C.P.] Rules 11 and 37 with the penalty provisions of § 1132(c)." *Verkuilen* at 412.

The Petitioner never made a request for the Plan to the Plan Administrator as contemplated by the statutory provision. Instead, Petitioner sought the Plan through discovery and Respondents provided the plan to Petitioner under the only proper discovery request in which it was sought.

Petitioner's original request for the production of the governing plan was issued by Petitioner's original counsel on May 4, 1999. In July of 1999, Petitioner moved to relieve his original counsel and hired present counsel as a replacement. Based on Petitioner's original counsel's

request, Respondent did not take any action in the case until replacement counsel was hired.[7]

Petitioner then submitted a second discovery request for the plan on October 4, 1999, which was outside of the time allowed in the District Court's scheduling order in this matter. A new scheduling order was consented to by all parties and a timely third request for the plan was issued by the Petitioner on April 10, 2000. By letter dated May 9, 2000, Respondents produced a copy of the plan as requested.

III. THE DISTRICT COURT PROPERLY APPLIED THE TEST FOR AWARDING COSTS AND ATTORNEY'S FEES UNDER ERISA.

A district court, in its discretion, may award attorney's fees and costs under ERISA. *See* 29 U.S.C. § 1132(g)(1); *Quesinberry v. Life Ins. Co.*, 987 F.2d 1017 (4th Cir. 1993). The five factors employed to guide the district court's discretion are:

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[7] Mr. Kozacki, Petitioner's initial counsel, served the first discovery requests on Respondents on May 4, 1999. Shortly thereafter, he notified Respondents that he intended to withdraw and shortly thereafter Petitioner executed a Termination of Representation, all prior to the date on which initial discovery responses were due. Before withdrawing, Mr. Kozacki reasonably requested that defense counsel refrain from pursuing the case until Petitioner retained replacement counsel. Defense counsel complied with this request, holding off filing motions, proceeding with discovery as well as waiting to notice depositions until notified that Mr. Johnson would be assuming Petitioner's representation. In September, defense counsel contacted Mr. Johnson to inquire how the delay created by change in counsel should be dealt with as well as informed Mr. Johnson that the discovery deadline was about to expire.

(1) degree of opposing parties' culpability or bad faith;

(2) ability of opposing parties to satisfy an award of attorneys' fees;

(3) whether an award of attorneys' fees against the opposing parties would deter other persons acting under similar circumstances;

(4) whether the parties requesting attorneys' fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA itself; and

(5) the relative merits of the parties' positions.

Id. at 1029.

Petitioner requests that this Petition be granted on the issue of whether judgment on an issue of liability is success on the merits for a Court to consider in awarding fees. However, as shown above, success on the merits is not one of the factors to guide the Court's discretion over fee awards. One of the factors does require the Court to consider the relative merits of the parties' position. The District Court properly weighed this factor. There was a finding that the Case Manager's decision was an abuse of discretion. However, the other judgment in the case, the summary judgment award to Respondent, totals more than twenty-two thousand dollars. Additionally, the District Court found that there was no abuse of discretion as to the ultimate decision by the Appeals Committee. Thus, the District Court's determination to weigh this factor in favor of the Respondents was proper.

CONCLUSION

For the foregoing reasons, the Petition for Writ of Certiorari should be denied.

Respectfully submitted,

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